Owensboro Health

Owensboro Health Use Only
MRN:
DOB:
Document Type: Release of Information

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Information

Patient Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email (optional): _____

Requested Format (Please check ONLY one)

☐ Paper Copy ☐ MyChart Patient Portal ☐ Email ☐ Fax ☐ CD ☐ USB flash drive
☐ EHI Export (Note: See EHI export section)

Delivery Method (Please check ONLY one)

☐ Mail ☐ Pickup ☐ Fax ☐ MyChart Patient Portal ☐ Email (encrypted) ☐ Email (NOT encrypted) (Note: If you would like us to send information over email not encrypted, this increases the risk that information could be read by an unauthorized third party.)

Reason or Purpose for the use and/or disclosure of the information

☐ Continued Care ☐ Patient Request ☐ Legal/Attorney ☐ Insurance/Payment
☐ Other (specify): _____

I authorize my health information to be released from:

☐ Owensboro Health Regional Hospital
☐ Owensboro Health Muhlenberg Community Hospital
☐ Owensboro Health Twin Lakes Medical Center
☐ Owensboro Health Medical Group (specify medical office): _____

An EHI export produced by Owensboro Health, Inc will include ALL electronic health information related to the patient across the OHI organization and all Community Connect Partners (Owensboro Pediatrics, Ohio Valley Nephrology Associates, Premier Medical Group, CareNow, and Dr. Tamberly McCoy).

I authorize my health information to be sent to: ☐ Me OR ☐ The address below

_____
(Name of hospital, physician, healthcare provider, other)

_____
Address City State Zip

_____
Phone Fax Email Address

Information to be released

Information to be released for the following date range _____ to _____
(Please check the records you would like released)

☐ Medical Records Abstract (e.g. H&P, Operative Reports, Consults, Test Results/Reports, Discharge Summary)
☐ Emergency Department Reports ☐ Operative/Procedure Reports ☐ Immunizations
☐ X-Ray Report(s) ☐ Lab Report(s) ☐ Billing ☐ Other _____

Release of Special Protected Records

I understand the following information may be included in my health records: information related to HIV/AIDS testing, the diagnosis or treatment of drug and/or alcohol (substance) abuse, information related to mental health or psychiatric disorders or genetic information.

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EHI Export

- Electronic Health Information (EHI) refers to "electronic protected health information (ePHI)" only to the extent that it would be included in the medical record. EHI does not include psychotherapy notes as defined in 45 CFR 164.501 or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
- EHI export files will be delivered in "computer readable format" (TSV) that may require the use of a special computer program.

Notice Regarding Delivery Mother's Record

I understand that if I give birth at Owensboro Health that a portion of my medical records will become part of the newborn medical record.

Expiration

This authorization shall become effective immediately and shall remain effective for 120 days from the date of signature.

Your Rights

- I understand that authorizing the disclosure of the information identified above is voluntary. I understand if I refuse to sign that my refusal will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility.
- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the location where the original request was submitted. I understand my revocation will be effective upon receipt and will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company where law provides my insurer with the right to contest a claim under my policy.
- I have the right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- I have the right to inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of.
- I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it.

Legally Authorized Representative

<u>If you are requesting records of an adult patient the following will apply:</u>

1) Power of Attorney: Must provide a copy of the POA document.
2) The Executor or Administrator of the adult deceased patient's estate. Must provide a copy of the qualification or order of appointment, signed by a judge as the executor or administrator over the estate.
    - If there is not an estate, court documents noting appointment of a personal representative must be provided.
3) Legal Guardian: Legal Guardian must present an order of appointment, signed by a judge, granting guardianship.

<u>If you are requesting records of a Minor patient the following will apply:</u>

1) Joint legal custody: Parent must provide custody papers.
2) Legal Guardian: Legal Guardian must present an order of appointment, signed by a judge, granting guardianship.

Signature (As required by law)

I have read and understand this information. I am the patient or authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Signature: _____ Date: _____ Time: _____
(Patient/Legal Representative)

If signed by Legal Representative, print name and relationship.

Name: _____ Relationship_____